A. Coordination of Benefits

Crisis Intervention and Health Insurance

If the recipient's Medicaid identification card indicates health insurance, providers must seek payment first from the health insurer. If you receive payment from the health insurer, enter the other insurance indicator (OI-P) in element 9 of the HCFA 1500 claim form and indicate the amount in element 29 of the HCFA 1500 claim form. Leave element 9 blank if you do not receive payment from the health insurer.

If no health insurance is indicated on the recipient's Medicaid identification card, do not enter any information in element 9 of the HCFA 1500 claim form.

Refer to Appendix 2 of this handbook for more information about completing HCFA 1500 claims for crisis intervention services.

B. Medicare/Medicaid Dual Entitlement

Dual-entitlees are recipients covered under both Medicare and Wisconsin Medicaid. Since crisis intervention is not a Medicare-covered service, providers should not seek Medicare payment. Therefore, providers must leave element 11 of the HCFA 1500 claim form blank.

C. QMB-Only Recipients

Qualified Medicare Beneficiary Only (QMB-only) recipients are eligible only for Wisconsin Medicaid payment of the coinsurance and the deductibles for Medicare-covered services. Since Medicare does not cover crisis intervention services, Wisconsin Medicaid does not pay the coinsurance and deductible for crisis intervention services.

D. Billed Amounts

Providers must bill their usual and customary charge for services provided. The usual and customary charge is the amount the provider charges for the same service when provided to a private-pay patient. For providers using a sliding fee scale for specific services, the usual and customary charge is the provider's charge for the service when provided to a non-Medicaid patient. Providers who do not have a usual and customary charge must bill Wisconsin Medicaid the estimated cost for the service provided. Providers may not discriminate against a Medicaid recipient by charging a higher fee for the service than is charged to a private-pay patient.

E. Managed Care Recipients

Refer to Section I of this handbook for information regarding billing for crisis intervention services provided to recipients who are enrolled in AFDC/Healthy Start HMOs or specialized managed care programs.

F. Presenting Problem Codes

When a recipient has a problem that needs crisis intervention services, these problems are called "presenting problems." Presenting problems are described in four-character codes that identify the presenting problems. Enter presenting problem codes in element 21 of the HCFA 1500 claim form. Providers may enter up to three codes on the claim form. Refer to Appendix 4 of this handbook for allowable presenting problem codes and to Section II of this handbook for more information about covered crisis intervention services.

Presenting problem codes are Medicaid codes. *The International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM) coding structure is not used to identify or describe presenting problem codes.

G. Procedure Codes

All HCFA 1500 claim forms require HCFA Common Procedure Coding System (HCPCS) codes. Wisconsin Medicaid denies claims or adjustments received without HCPCS codes. Refer to Appendix 3 of this handbook for allowable HCPCS codes and their description and to Appendix 8 of this handbook for staff qualifications for crisis intervention billing levels.

H. Quantity

Bill all services in hourly units. Refer to Appendix 6 of this handbook for rounding guidelines.

I. Place of Service

Refer to Appendix 6 of this handbook for a complete list of allowable place of service (POS) codes. Enter POS codes in element 24b on the HCFA 1500 claim form. Refer to Appendix 2 of this handbook for claim form completion instructions.

J. Type of Service

For crisis intervention services, the type of service (TOS) is always "1" on the HCFA 1500 claim form. Enter the TOS in element 24c on the HCFA 1500 claim form. Refer to Appendix 2 of this handbook for claim form completion instructions.

K. Billing for Multiple Staff

When two or more staff are providing services at the same time and using the same procedure code (e.g., W9558 - two "other" staff providing crisis linkage and follow-up), the providers must accumulate their time and bill using only one line on the claim form.

Example of billing for multiple staff: A nurse and a social worker provide three hours of crisis linkage and follow-up together. Appendix 8 of this handbook shows that both of these professionals are at the RN/MS billing level; therefore, these services are both under the same W9557 procedure code. When billing for crisis linkage and follow-up, these staff members must bill under procedure code W9557 for a total of six hours and combine their total charges for these services. All of this information must be entered in the appropriate place on the same line of element 24 on the HCFA 1500 claim form.

L. Claim Submission

Paper Claim Submission

Submit claims using procedure codes for crisis intervention services on the HCFA 1500 claim form. Wisconsin Medicaid denies claims for crisis intervention services submitted on any other paper form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.

Neither Wisconsin Medicaid nor the fiscal agent provide the HCFA 1500 claim form. Claim forms are available from many suppliers. One supplier is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
(800) 362-9080 (toll-free)

Mail completed claims for payment to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

L. Claim Submission (continued)

Paperless Claim Submission

As an alternative to submission of paper claims, the fiscal agent may process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. All claims that providers submit are subject to the same Medicaid legal requirements. Providers submitting electronically usually reduce their claim submission errors. For more information on paperless claim submission, contact:

EMC Department
EDS
6406 Bridge Road
Madison, WI 53784-0009
(608)221-4746

Claims Submission Deadline

The fiscal agent must receive all claims for services provided to eligible recipients within 365 days from the date of service. This policy applies to all initial claim submissions, resubmissions, and adjustment requests.

Refer to Section IX of Part A, the all-provider handbook, for exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals.

M. Follow-Up to Claim Submission

Providers are responsible for initiating follow-up procedures on claims submitted to the fiscal agent. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. The fiscal agent takes no further action on a denied claim until the information is corrected and the provider resubmits the claim for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to the fiscal agent. Section X of Part A, the all-provider handbook, includes detailed information about:

- The Remittance and Status Report.
- Adjustments to paid claims.
- Return of overpayments.
- Duplicate payments.
- Denied claims.
- Good Faith claims filing procedures.